Authorization to Use and Disclose Health Information

Use this form to request authorization for the release of Protected Health Information (PHI), including patient profile or prescription records to your authorized representative named in Section 2 below.

1. Member Information: This section must be fully completed to ensure proper reimbursement of your claim				
First Name:	Last Name:	MI:	Phone Number:	
Address:	City:	State:	Zip Code:	
Date of Birth:	◯ Male ◯ Female	Member ID Number (refer to your benefits card):		

2. Authorized Representative's Information				
I authorize VerusRx, LLC to use and disclose my PHI to the person named below. I understand there are certain parties that must protect the privacy of my PHI. These are health care providers and other parties who are required to do so under federal or related state laws. If my authorized representative is not a health care provider or another party required to protect my PHI, it could be discussed and/or released by my authorized representative without my permission.				
First Name:	Last Name:	MI:	Phone Number:	
Address:	City:	State:	Zip Code:	
Date of Birth:	◯ Male ◯ Female	Relationship to Member: ◯ Family Member ◯ Friend ◯ Health Care Provider ◯ Other:		

3. Protected Health Information to Disclose

Please describe the information covered by this authorization. I understand by leaving this section blank, I am authorizing the disclosure of my PHI, including my patient profile, and pharmaceutical records to my representatives.

Description:

4. Expiration and Revocation

I understand I have the right to end this authorization at any time. I understand that, if I do not wish the person named in Section 2 to remain my authorized representative, I must cancel this authorization in writing and fax notification to (800) 856-0327 or mail the notice to the address listed below.

VerusRx, LLC
8150 N. Central Expressway
Suite 1700
Dallas, TX 75206

I understand that a cancellation of this authorization has no effect on disclosures or uses of PHI by VerusRx, LLC before receiving my cancellation notice.

I request that this authorization will expire on this date (MM/DD/YYYY):

If I do not provide an expiration date, I am aware that this authorization is valid for **sixty (60) months from the date of my signature as noted below.**

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5. Authorization and signature of individual or individual's LEGAL representative			
I have read and understood the content of this authorization to Use and Disclose PHI. This authorization describes my request of VerusRx, LLC. I understand, by signing this form, I am voluntarily giving my permission for VerusRx, LLC to use and/or disclose my PHI to the person named in Section 2. Any services otherwise provided to me by VerusRx, LLC will not be affected by my decision to provide this authorization.			
Member Signature:	Date:		
Witness Signature: (A witness signature is only needed if the member is unable to sign or if the witness is an interpreter)	Date:		
If this authorization is signed on the member's behalf, by his/her legal representative, please attach documentation of legal representative designation and complete the following:			
Legal Representative's Name:	Date:		
Address:	City:	State:	Zip Code:
Relationship to Member: ◯ Family Member ◯ Friend ◯ Health Care Provider ◯ Other:			
6. I understand that I have a right to request and receive a copy of VerusRx, LLC Notice of Privacy Practices at http://myverus-rx.com			
◯ Yes ◯ No			
7. I understand that a photocopy of this authorization is as valid as the original			
◯ Yes ◯ No			
8. Fax the form to (800) 856-0327 or mail the completed form to:			
VerusRx, LLC **8150 N. Central Expressway** **Suite 1700** **Dallas, TX 75206** • Please allow up to 30 days from the time you send this form until the time you receive the response. • Please attach receipts, labels, and/or a printout from the pharmacy for verification.			